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MEMORANDUM

DATE: November 7, 2008

TO: Managed Risk Medical Insurance Board Members

FROM: Lesley Cummings
Executive Director

SUBJECT: Healthy Families Program Current Year Deficiency and the Need to Establish a Waiting List

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This last month, the Healthy Families Program (HFP) experienced another notable enrollment milestone. There were 900,000 children enrolled. It is an honor and privilege to provide health, dental, and vision coverage to 900,000 children who otherwise would have no coverage. Research has shown that having coverage is of enormous importance in children's school performance, future success and long term health status. California has the largest SCHIP enrollment of any state in the country, with a greater enrollment level than the second and third largest states combined.

However, the program is, in some ways, a victim of its success. California, like a number of states, is in the midst of a severe economic downturn. Obtaining sufficient state funds to match federal funds has become very challenging. In fact, HFP does not have sufficient state funds in the current year to fund projected enrollment.

Current Year Budget Deficiency

To say this in a more direct way, staff projects a General Fund shortfall of $17.2 million in the current year. This consists of $14.1 million GF due to the fact that the enacted budget assumed that departments would implement budget balancing reductions (BBR's) on November 1, 2008. However, MRMIB is implementing the HFP BBR's for HFP on February 1, 2009. This is the first day of the fifth month following signature of the budget, the timeframe specified for HFP BBR implementation in the budget trailer bill. Additionally, the budget assumes $3.1 million in GF savings due to a project caseload decrease attributable to the HFP premium increases. Given the severe decline in the economy and the need to assure that the program does not overspend GF dollars, we do not feel confident assuming these savings.

The five month timeframe results from the fact that to implement program changes, HFP must modify contracts with plans, negotiate final plan rates, and finalize plan coverage areas. Then MRMIB conducts an open enrollment process in which it notifies 900,000 subscribers of program and coverage area changes (with notices in five languages), offers subscribers the opportunity for an income re-evaluation, and transfers subscribers whose plans have left their coverage area and transfers any other subscribers that want to change plans. See Attachment 1 for more detailed information on caseload.

Legally Required Response

As you know, the HFP statute requires that the Board operate the program within the funding available. Insurance Code Section 12693.21(n) says that the Board is to "maintain enrollment and expenditures to ensure that expenditures do not exceed amounts available in the Health Families Fund and, if sufficient funds are not available to cover the estimated cost of program expenditures, the Board shall institute appropriate measures to limit enrollment."

Limited and Difficult Options

The Board's options for responding to the deficiency are limited. The Legislature can provide additional funding for the program or make changes to HFP benefits or eligibility income criteria. Implementing any program changes, however, would require the implementation time period detailed above. It is impractical to expect any additional savings in the current year.

The only tool in the Board's control to manage costs in the current year is to limit enrollment. If the Board does not cap enrollment, it would have to take other, more catastrophic actions later. As you know, the Board is authorized to disenroll children at Annual Eligibility Review if needed to manage within existing funds. Capping enrollment, rather than eliminating coverage that a child currently has, seems the preferable path. Staff estimate that the waitlist would have to be established on December 18th, the day after the December 17th Board meeting, to live within the General Fund appropriation the Budget Act provided for the current year. The December 18th date takes into consideration a series of complex assumptions, including the fact that there are twenty days that can elapse between receipt of an application and enrollment.

The number of children to be waitlisted is significant. HFP has been experiencing 27,125 new enrollments per month, not including AIM-linked babies who will continue to be enrolled. If that level of new enrollment continues for the six month period, 162,750 would be waitlisted. The BBR that increased premiums for families with incomes above 150 percent of Federal Poverty Level also assumed that fewer families would enroll or remain in coverage. If that occurs, the figure would be 100,000. Of course, if financial circumstances improve and it were financially possible to enroll children form the waitlist, we would do so, consistent with HFP regulations.

Possible Response by the Administration, Legislature, and the Federal Government

The Governor just convened a special session of the legislature to address a deficit of immense proportions. HFP has been blessed through the years to have been a high priority for both the Governor and the Legislature. But, in the context of the state's fiscal emergency, policymakers also have limited choices. Thus, the Board cannot presume that it will receive funding to offset the deficit. What is clear is that the Board is required by law to manage the program within the funds provided.

Federal Funding Issues. Another fiscal pressure on the program is that the amount of federal SCHIP funds available after March 30, 2009 is unknown. Congress and the Bush Administration were at an impasse over the purpose and the funding for SCHIP and the issue was pushed to the next Congress and Administration. The program is dependent on quick action by the federal government.

California is not alone in having a difficult time putting up state matching funds for SCHIP. The federal government is considering steps it could take as an economic stimulus for states hard hit by the national economic downturn. It would be extremely helpful it as part of the economic stimulus package, the federal government would 1) provide funding for the remainder of the federal fiscal year so that state's don't have to guess how much federal funding will be provided past March 09 and 2) increase the federal matching rate for SCHIP, at least for a year or so.

Board Determination. Staff suggests that the Board discuss the HFP deficiency at two Board meetings, November 19th and December 17th, to provide the public with the opportunity to comment. The Board can make its determination about the need for a waiting list at the December meeting. But, as noted above, the waitlist would have to go into effect the next day, December 18th, to achieve adequate savings.

Attachments. There are two attachments to this email. Attachment 1 shows the caseloads and expenditures for the current year under various scenarios. Attachment 2 describes how MRMIB would manage the waitlist, consistent with the regulations adopted a year ago.

The MRMIB staff is deeply sorry to have to bring this issue to the Board. We are well aware that establishing a waiting list is antithetical to the Board's mission and desires. But, it is consistent with the Board's obligation.

HFP Caseload Scenarios

Attachment 1

	1 2008 Budget Act BBRs 11/1/08	2 2008 Nov Estimate BBRs 2/1/09	3 2008 Nov Estimate Waitlist as of 12/17/08 BBRs 2/1/09
Jul-07	825,425	825,425	825,425
Aug-07	832,204	832,204	832,204
Sep-07	836,505	836,505	836,505
Oct-07	839,793	839,793	839,793
Nov-07	853,538	853,538	853,538
Dec-07	865,785	865,785	865,785
Jan-08	845,909	845,909	845,909
Feb-08	845,323	845,323	845,323
Mar-08	858,026	858,026	858,026
Apr-08	861,661	861,661	861,661
May-08	872,589	872,589	872,589
Jun-08	877,400	877,400	877,400
Jul-08	879,559	879,559	879,559
Aug-08	883,332	883,332	883,332
Sep-08	895,320	895,320	895,320
Oct-08	899,626	899,626	899,626
Nov-08	897,955	904,389	904,389
Dec-08	895,985	908,916	908,916
Jan-09	894,755	913,340	887,972
Feb-09	893,774	911,502	867,262
Mar-09	892,331	909,144	846,776
Apr-09	892,249	908,005	826,538
May-09	891,861	906,760	806,509
Jun-09	891,604	905,586	786,719

Expenditures

	2008 Budget Act	BBRs 2/1/09	Waitlist as of 12/17/08
2008-09			
GF	$397,461,000	$411,555,000	$397,333,000
TF	$1,102,852,000	$1,145,310,000	$1,105,470,000

Attachment 1

Scenario Assumptions

	Scenario 1 Budget Balancing Reductions Implemented November 2008	Scenario 2 Budget Balancing Reductions Implemented February 2009	Scenario 3 Budget Balancing Reductions Implemented February 2009 and Wait List on December 17, 2008
Estimate Version	2008 Budget Act Updated November 2008	November 2008	November 2008
Average Monthly Disenrollments	26,000 until 10/30/2008 30,500 after 11/1/2008	26,000 until 1/31/2009 30,500 after 2/1/2009	26,000 until 12/31/2008 17,443 after 1/1/2009
Average Monthly New Enrollments	28,000 until 10/30/2008 24,300 after 11/1/2008	28,000 until 1/31/2009 24,300 after 2/1/2009	28,000 until 12/31/2008 875 (AIM-linked babies) after 1/1/2009
BBR: Premium Increase:	Assumes premium increase for certain income categories effective 11/1/2008 which would result in increased disenrollments and decreased enrollments reflected above	Assumes premium increase for certain income categories effective 2/1/2009 which would result in increased disenrollments and decreased enrollments reflected above	Assumes premium increase for certain income categories effective 2/1/2009 which would result in increased disenrollments and decreased enrollments reflected above
BBR: Plan Rate Reductions	Assumes 5 percent plan rate reduction to 07/08 rates effective 11/1/2008	Assumes 5 percent plan rate reduction to 07/08 rates effective 2/1/2009	Assumes 5 percent plan rate reduction to 07/08 rates effective 2/1/2009
Changes in Plan Coverage Areas	Assumes plans will change coverage areas resulting in net increased costs of $0.8 million GF in CY due to subscribers changing plans	Assumes plans will change coverage areas resulting in net increased costs of $0.5 million GF in CY due to subscribers changing plans	Assumes plans will change coverage areas resulting in net increased costs of $0.5 million GF in CY due to subscribers changing plans
BBR: Dental Cap	Assumes that dental cap will not be implemented until BY	Assumes that dental cap will not be implemented until BY	Assumes that dental cap will not be implemented until BY
Mandatory Disenrollments at AER	None	None	None
Number of enrollees on June 30, 2009	891,604	905,586	786,719

Healthy Families Program (HFP)
Waiting List Process and Administration

As explained in the memo to the Board from the Executive Director, the Board will be deliberating at its November and December meetings on the need to establish a waiting list for enrollment into HFP. The Board must curtain enrollment if "sufficient funds are not available to cover the estimated costs of program expenditures and that it is necessary to limit enrollment in the program to ensure that expenditures do not exceed amounts available for the program, the program shall establish a waiting list." (Title 10, California Code of Regulations, Section 2699.6603 (a)) While the Board has the authority to also require disenrollments of children at Annual Eligibility Review (AER), staff do not think such action is necessary at this time.

This document sets forth how MRMIB would administer the waitlist.

Wait List Administration

The Single Point of Entry (SPE) will continue to income screen children whose applications are submitted on the joint applications for potential Medi-Cal or HFP eligibility.

Medi-Cal. If an income screening indicates that a child would be eligible for Medi-Cal, the child will be temporarily enrolled in Medi-Cal (accelerated enrollment, if eligible) and the application will be forwarded to the county welfare department in the child's county of residence for a final eligibility determination. This is the same process that occurs today.

HFP. If an income screening indicates that a child would be eligible for HFP:

Applications (and add-a person forms) received at the HFP prior to the Board's finding, will be processed until an eligibility determination has been made. A child will be enrolled if determined eligible.

Applications (and add-a-person forms) received after the Board has made its finding (12/17/08), will be placed on a waiting list in the order in which the application is received. List order will be based on the date the application was received. HFP will not make an eligibility determination prior to a child being placed on the wait list.

The HFP will provide a written notification to the applicant advising them of the child's placement on the waiting list and indicating that the applicant will be notified when sufficient funds are available. This notice will be provided in 5 languages (English, Spanish, Chinese, Korean and Vietnamese).

Exceptions to the waiting list: AIM linked infants; current HFP subscribers who successfully requalify during their AER period; and HFP subscribers that successfully appeal an incorrect decision will be enrolled in the program and are not subject to the wait list.

Admissions from the Wait List

When MRMIB's Executive Director determines that sufficient funds are available to enroll some or all of the wait listed children, the program will enroll the number of eligible wait listed children for whom sufficient funds are available, based on the order of the wait list.

HFP will notify applicants of wait listed children in writing that their children may be able to be enrolled. The notice will request any necessary information to complete the initial application, including updated income documentation, so that a final eligibility determination can be made. A child will be enrolled if HFP makes a final determination of eligibility.

Applicants of wait listed children will have twenty (20) calendar days (the established regulatory time frame) to provide information needed to complete the application.

Questions or Inquiries

Any questions regarding the HFP wait list process can be sent to www.HFPwaitlist@MRMIB.ca.gov.

Coping With SCHIP Enrollment Caps: Lessons From Seven States' Experiences

Although capping enrollment was necessary, the states that did tried to mitigate the impact on families until enrollment could resume.

by Ian Hill, Brigette Courtot, and Jennifer Sullivan

ABSTRACT: Seven states with separate (as opposed to Medicaid expansion) State Children's Health Insurance Programs (SCHIP) implemented enrollment caps during the 2001–2003 recession. Interviews with SCHIP officials and Covering Kids and Families grantees in these states examined implementation policies and their effects on enrollment, outreach, and public support. Enrollment caps were generally maintained for less than a year and resulted in large spending reductions, but enrollment declined steeply. Most key informants indicated that caps were preferable to reversals of simplified enrollment, comprehensive benefits, and low cost sharing and thus offered policymakers an important tool for controlling costs. [*Health Affairs* 26, no. 1 (2007): 258–268; 10.1377/hlthaff.26.1.258]

A NATIONAL RECESSION, STRUGGLING STATE and local economies, and increased public spending demands have made it difficult for states to maintain balanced budgets in recent years. Most have attempted to contain costs by trimming a broad range of programs, including Medicaid and the State Children's Health Insurance Program (SCHIP).[1] Although SCHIP, noteworthy for its popularity among policymakers, providers, and the public, was relatively well protected during the early years of budget tension, the length of the recession prompted a number of states to cut SCHIP costs.[2] Most often, states stopped doing outreach, reversed enrollment simplifications, and increased cost sharing.[3] Seven states took a more dramatic step by capping SCHIP enrollment. This paper examines the experiences of these seven states.

Background

In 1997, when SCHIP was passed, states were given considerable latitude to either expand Medicaid, create new "separate" child health programs, or combine these two strategies. More than three-quarters of states adopted separate pro-

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grams, either alone or in combination with smaller Medicaid expansions.

The thirty-nine states that created separate programs did so to take advantage of the flexibility that was permitted by the statute, setting out to test new models of public coverage that were "more like private insurance."[4] Typically, these programs are characterized by benefit packages that, although broad, do not offer the full protection of Medicaid and entail nominal cost sharing in the form of monthly premiums or copayments, or both. Most importantly, unlike Medicaid, these programs can be closed to control state spending.

All SCHIP programs—Medicaid expansion and separate programs alike—invested unprecedented resources in efforts to promote child enrollment during the early years of implementation. States launched public awareness campaigns to inform families of the availability of new coverage and dramatically simplified enrollment procedures.[5] State-funded outreach was augmented by private-sector efforts, most notably the Robert Wood Johnson Foundation's (RWJF's) Covering Kids and Families (CKF) initiative. CKF grants supported outreach, simplification, and coordination activities in more than 140 community-based projects in forty-five states and the District of Columbia.

These public- and private-sector initiatives spurred steady enrollment gains. Between 1997 and 2004, total SCHIP enrollment grew to nearly 3.95 million children, and rates of uninsurance among low-income children dropped from more than 22 percent to approximately 15 percent.[6] Unfortunately, when the economy began to slow in 2001 and worsen in 2002 and 2003, many states felt that they could not sustain growth in their programs. Between 2001 and 2003, seven states—Alabama, Colorado, Florida, Maryland, Montana, North Carolina, and Utah—took the dramatic step of capping enrollment.

Study Data And Methods

In October and November 2004 we conducted telephone interviews with SCHIP and CKF grant directors in each of the seven states that enacted enrollment caps.[7] We asked informants to discuss the factors that led to both the imposition and the lifting of caps, policies that were adopted to manage implementation, caps' impact on SCHIP enrollment and other aspects of the program, and state and local officials' strategies to mitigate the caps' negative effects. Administrative data were obtained to document enrollment trends. To prepare for our interviews, we reviewed existing literature on enrollment caps.[8] Following commonly accepted qualitative research methods, interview notes were independently reviewed, and responses were categorized using data collection forms that mirrored the interview protocols. The analysis entailed comparing and contrasting the responses within each category, noting and discussing dominant themes and divergent opinions, and summarizing findings by topic area. This study was conducted as part of an evaluation of CKF, begun in 2002 and designed to assess grantees' outreach, simplification, and coordination strategies.

Study Results

Worsening economic conditions and tight state budgets were the primary factors that spurred state policymakers to impose enrollment caps in the study states. Rapidly growing SCHIP enrollment contributed to budget pressures, and enrollment caps were viewed as a way to immediately control program growth and, in turn, spending. Federal regulations, however, did not specify how states should implement caps. Thus, each state introduced its own cap, identified areas where policies were needed to guide implementation, and developed its own rules.

■ **Policies for cap implementation.** Our study found that no two states operated their enrollment caps in precisely the same way. Rather, states adopted a variety of policies pertaining to wait lists, exemptions, and other key areas (Exhibit 1).

Waiting lists. State administrators in four states chose to maintain waiting lists of children who would have qualified for SCHIP while enrollment was capped. Directors in these states reported that the lists served many purposes, including reducing parental confusion, helping enrollment "rebound" when caps were lifted, and keeping policymakers and the public aware of the demand for coverage among children. The programs choosing not to keep waiting lists indicated that they wanted to avoid the administrative burden of creating and maintaining one, and one administrator acknowledged policymakers' desire to avoid negative publicity.

Exemptions. State officials also had to decide whether any children should be exempted from the cap. Two states chose not to exempt any children. Five others identified an array of exempt groups, including (1) children who "age out" of Medicaid (that is, become eligible for SCHIP when their age exceeds the eligibility threshold of Medicaid); (2) children who lose Medicaid eligibility as a result of increases in family income (that is, children whose lost eligibility would have made

EXHIBIT 1
State Children's Health Insurance Program (SCHIP) Enrollment Cap Policies In Seven States, 2004

	AL	CO	FL	MD	MT	NC	UT
Waiting list	●		●		●	●	
Modified premium payment policies			●	●			
Modified renewal policies	●	●	●	●	●	●	●
Groups exempt from cap[a]							
Children "aging out" of Medicaid		●			–[b]		●
"New" children in existing SCHIP families		●			●		●
Children with special health care needs			●[c]				
Families in/out of active-duty military					●		●
Families with income increases				●	●		

SOURCE: Telephone interviews with SCHIP officials, fall 2004.

[a] Florida began allowing exemptions for Medicaid age-outs and families with income increases when the state put time limits on enrollment periods.

[b] Montana stopped exempting this group in May 2004.

[c] Florida uses a set of screener questions on the KidCare application to identify children with special health care needs.

them eligible for SCHIP, but for the cap); (3) "new" children in existing SCHIP families (that is, children born or adopted into families that already had children in SCHIP); (4) children with special health care needs (that is, children with chronic illnesses or disabilities for which state officials sought to extend extra protection); and (5) children in military families (that is, children who lose health coverage provided by the U.S. Defense Department when their parents' active duty ends).

Premium nonpayment. SCHIP rules allow states with separate programs to impose premiums on participating families; those that do must then decide how to treat families who fall behind in their payments (offering a "grace period" or extending extra time to pay), and when to permit children who are disenrolled because of nonpayment to reenroll (often after a "lockout" period). After implementing enrollment caps, some states modified their cost-sharing policies. For example, Maryland eliminated its lockout period so that children who were disenrolled for premium nonpayment could immediately reenroll once the cap was lifted.

Renewal. In each of the states with caps, children facing eligibility renewal were not subject to the enrollment cap as long as they complied with the program's renewal procedures. The presence of a cap underscored for families the importance of maintaining coverage, and many states simplified renewal procedures while caps were in place. Some intensified outreach to inform families about the importance of renewing on time during the freeze; others introduced preprinted renewal forms that were simple for families to review and submit.

Impacts on enrollment. Three states—Montana, North Carolina, and Utah—enacted enrollment caps in 2001 at the outset of the recession, in response to rapidly growing program enrollment and concerns about state budget deficits (Exhibit 2). The remaining four states—Alabama, Colorado, Florida, and Maryland—capped enrollment between July and November 2003 at the height of the national recession. Enrollment caps were short-lived in six states; every state except Montana lifted its cap on SCHIP enrollment within one year of enactment. Alabama, Colorado, Maryland, and North Carolina returned to full-year open enrollment after lifting their caps, while Florida and Utah switched to systems where enrollment was allowed only at certain times of year. During spring 2005, however, both states returned to full year-round open enrollment. As of this writing, Montana has continued its cap, permitting children from its waiting list to enroll each month as attrition allows.

Although news that enrollment caps were relatively short-lived in most states is positive, this is offset by the fact that the caps took a serious toll on children's coverage. While caps were in place, total enrollment dropped by an aggregate 61,133 children (15 percent) in the six states that capped and then reopened enrollment. Rates of attrition ranged from 6 percent in Florida and Maryland to 29 percent in North Carolina (Exhibit 2). The summaries below and Exhibits 3 and 4 provide more detail on each state's experience.

EXHIBIT 2
Program Characteristics And Enrollment Cap Overview, States With State Children's Health Insurance Program (SCHIP) Enrollment Caps, 2004

			Summary of enrollment trends			
Program name (state)	**Program type**	**Cap in place**	**Enrollment at start of cap**	**Enrollment at end of cap**	**Percent change**	**Resolution**
ALLKids (AL)	Separate	9/03–3/04	62,449	54,932	–12	Full-year open enrollment
Child Health Plan Plus (CO)	Separate	11/03–7/04	50,822	37,165	–27	Full-year open enrollment
Healthy Kids (FL)	Combination	7/03–3/04	326,755	308,648	–6	Time-limited enrollment periods[a]
MCHP Premium (MD)[b]	Combination	7/03–6/04	6,501	6,111	–6	Full-year open enrollment
Children's Health Insurance Program (MT)	Separate	1/01–present	9,503	–[c]	–[c]	Rolling cap
NC Health Choice (NC)	Separate	1/01–10/01	72,024	51,294	–29	Full-year open enrollment
Children's Health Insurance Program (UT)	Separate	12/01–6/02	26,427	21,931	–17	Time-limited enrollment periods[a]

SOURCE: Telephone interviews with SCHIP officials, fall 2004.

[a] As of this writing, Florida and Utah had passed legislation that returned the programs to full, year-round open enrollment for state fiscal year 2005. Therefore, Florida adopted time-limited open enrollment from January through June 2005. Utah adopted time-limited open enrollment from June 2002 through June 2005.

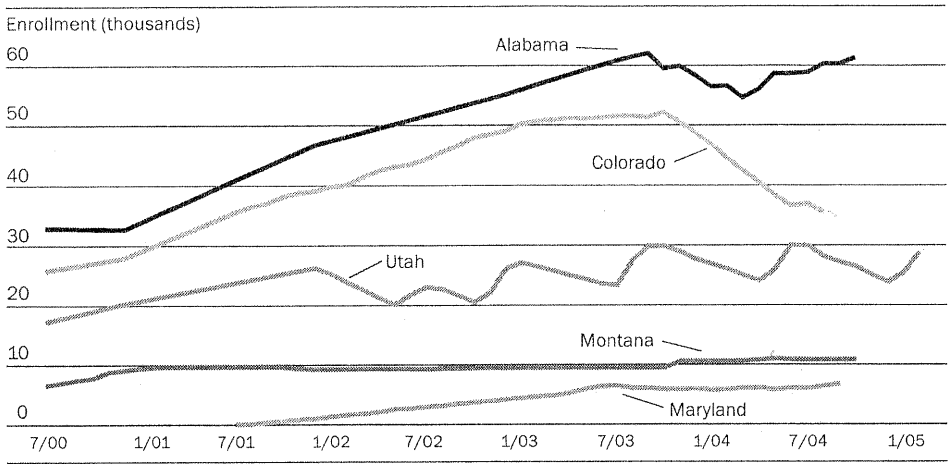
[b] Maryland's cap applied only to those new applicant children in families earning 200–300 percent of the federal poverty level.

[c] Not applicable.

Alabama's enrollment cap was officially in place from October 2003 to August 2004. However, in November 2003 and January and February 2004, roughly 2,000 children were allowed to enroll from the waiting list. In March 2004, because of negative publicity, the state legislature fully funded SCHIP for fiscal year 2005, effectively ending the cap. During the six-month period when enrollment was restricted, total enrollment fell by approximately 7,500 children (12 percent), from 62,499 to 54,932. In the six months following the lifting of the cap, Alabama's SCHIP enrollment rebounded to near its previous peak, reaching approximately 62,000 children by October 2004.

Colorado's enrollment cap was in place from November 2003 until July 2004. SCHIP officials chose not to maintain a waiting list, believing that it would be administratively burdensome, and thus could not gauge the level of unmet demand during the year. Policymakers entered 2004 aiming to lift the cap, and the governor's budget included full funding for SCHIP. The provision passed easily, and enrollment was reinstated at the beginning of the new fiscal year. During the eight-month cap, however, program enrollment dropped by nearly 27 percent, from 50,822 to 37,165.

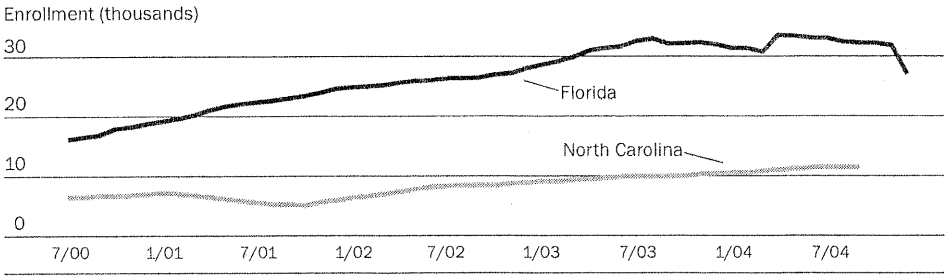
EXHIBIT 3
State Children's Health Insurance Program (SCHIP) Enrollment Trends In Five States, July 2000–February 2005



SOURCE: Telephone interviews with SCHIP officials, fall 2004.
NOTES: Maryland's cap applied only to new applicant children in families earning 200–300 percent of the federal poverty level.

Florida's enrollment cap was implemented in July 2003 and stayed in place until March 2004, during which time a waiting list grew to nearly 91,000 children.[9] Because of the state's "passive" renewal system, Florida had less attrition during its cap, losing roughly 18,000 children (6 percent).[10] Considerable political pressure to lift the cap existed at the beginning of 2004, and the state legislature quickly did so, fully funding coverage of children on the waiting list; this led to an enrollment jump of more than 28,000 children in March 2004. However, in return for full funding, the legislature removed many of the state's simplified enrollment and renewal policies, replacing them with new rules that would suppress future enrollment. Specifically, the state moved to periodic, rather than year-round, enrollment; stopped allowing families to "self-declare" income at application; and

EXHIBIT 4
State Children's Health Insurance Program (SCHIP) Enrollment Trends In Two States, July 2000–December 2004



SOURCE: Telephone interviews with SCHIP officials, fall 2004.

moved from a "passive" renewal process to a more traditional "active" process whereby families must update their information and submit new income verification to continue coverage.[11] By December 2004, with these policies in place, Healthy Kids enrollment dropped by nearly 66,000 children, or 20 percent. Amid renewed pressure to restore children's coverage, new legislation was passed in June 2005 allowing children to be enrolled in Healthy Kids throughout the year.

Maryland capped SCHIP enrollment in July 2003 under legislation that required the cap to "sunset" in one year unless action was taken to extend it. No such action was taken, as the cap garnered considerable negative publicity for the governor and legislature. Maryland's cap affected only new applicants from families earning 200–300 percent of poverty, and so it had relatively limited effects on enrollment and costs.[12] Maryland's enrollment in the 200–300 percent band fell 6 percent, from 6,501 to 6,111, during the year.[13] Enrollment rebounded quickly after the cap was lifted, surpassing its previous zenith in just two months.

Montana policymakers, despite having set a low upper eligibility threshold of 150 percent of poverty, determined that funds were insufficient to permit open-ended enrollment and implemented a cap at the start of 2001. Montana has continuously kept a waiting list of eligible children and enrolls children from that list each month, based on attrition. As a result, SCHIP enrollment remained virtually level between January 2001 and November 2003. In fall 2003, policymakers diverted the state's federal fiscal relief funds to SCHIP to clear the list, which had grown to 1,300 children. Since that time, enrollment has remained constant at slightly below 11,000 children.

North Carolina garnered much national attention when it became the first state to cap enrollment in January 2001. The state confronted this decision when it became clear that escalating enrollment would exceed expectations (based on Current Population Survey data) and the state's appropriation for SCHIP. Enrollment stood at 72,024 in January 2001 and plunged 29 percent, to 51,294, by October of that year. State officials described imposing the cap as very painful, especially when the waiting list peaked at more than 34,000 children. Despite the forecast for an overall state budget deficit in state FY 2002, legislators worked to reverse the cap by November 2001. In the ensuing six months, enrollment rebounded steadily until it exceeded the level witnessed at the start of the cap. The specter of an enrollment freeze has loomed over every legislative session since 2001, but policymakers have managed to avoid repeating what everyone agrees was a challenging period in North Carolina's SCHIP history.

From the outset, Utah policymakers created SCHIP in the image of private insurance. Thus, when enrollment began exceeding the state SCHIP appropriation, the notion of shifting to a system of periodic enrollment was consistent with a private insurance model. In December 2001, when the state first froze enrollment, it also reduced the scope of its dental benefit and raised premiums for eligible families, bringing the program even closer in line with typical private products.[14] After

that, Utah held five "open" enrollment periods—in June 2002, November 2002, July 2003, May 2004, and January 2005—during which enrollment rebounded to 23,000–31,000 children. During each of the ensuing "closed" months, attrition rates ranged from 11 percent to 23 percent. This see-sawing enrollment ended in May 2005 with the passage of a bill extending full funding to Utah's SCHIP program, thereby permitting the state to enroll children throughout the year.

Attrition and rebound. Exhibit 5 displays the average monthly rates of enrollment attrition recovery that occurred while caps were in place and after caps were lifted. Coupling this information with that included in Exhibit 1, one can observe whether or not various state policies surrounding cap implementation were correlated with differing rates of attrition or rebound. Our analysis, while based on limited data, suggests the following.

Passive renewal may moderate attrition. Florida's average monthly rate of attrition while it had "passive renewal" was 0.69 percent; this rate rose to 2.44 percent when it did away with passive renewal. Three other states with active renewal (Alabama, Colorado, and North Carolina) experienced similar monthly attrition of 2.0–3.36 percent; Maryland imposed its cap on a small subset of its enrollees. Utah, however, also adopted passive renewal, and its monthly attrition was 3.2 percent, a rate in line with other active-renewal states.

Waiting lists might not improve enrollment recovery. Our data suggest that states without waiting lists (Maryland, Utah) have stronger enrollment recovery than those with lists (Alabama, Florida, North Carolina). But pent-up demand and well-advertised open enrollment periods could explain why Utah experienced average monthly recovery of 10.65 percent. At the same time, Alabama's enrollment of 6,000 children from its waiting list while its cap was in place likely attenuated both the demand and the enrollment recovery rate.

EXHIBIT 5
Average Monthly State Children's Health Insurance Program (SCHIP) Enrollment Attrition (During Enrollment Caps) And Average Monthly Enrollment Recovery (After Enrollment Caps)

	Average monthly attrition (%)	Average monthly recovery (%)
Alabama	-2.01	1.75
Colorado	-3.36	–[a]
Florida	-0.69, -2.44[b]	9.09
Maryland	-0.55	4.07
Montana	–[c]	–[c]
North Carolina	-2.99	7.60
Utah	-3.20	10.65

SOURCE: Telephone interviews with SCHIP officials, fall 2004.

[a] Not available.

[b] Florida experienced an average 0.69% decline while the state had a passive renewal process, and an average 2.44% decline in enrollment after the state adopted an active renewal process.

[c] Not applicable.

Exemption could offset attrition. One might hypothesize that exempting certain children from caps could offset rates of attrition, while more generous premium nonpayment policies might slow attrition and improve recovery. With the limited data available for this study, however, we were unable to observe such effects.

■ **Impacts on other aspects of SCHIP.** In addition to highly visible impacts on program enrollment, SCHIP and CKF officials told us of the "ripple effect" that caps had on outreach, public trust in SCHIP, and retention, as summarized below.

Outreach. Enrollment caps appear to have a chilling effect on outreach, at least temporarily. CKF grantees described their reluctance to conduct outreach while programs were capped. Staff in North Carolina told how the cap dampened the enthusiasm of community volunteers. Colorado officials said that some workers were reluctant to do outreach even after the state's cap was lifted for fear of driving up enrollment too quickly and necessitating another cap. After the initial shock, however, outreach agencies adjusted their messages and strategies to emphasize renewal or applications for Medicaid. Eventually, states and CKF partners were eager to promote coverage once caps were lifted.

Public trust. Key informants told us that enrollment caps caused much confusion for parents. Fear that SCHIP programs had been entirely closed was widespread. Alabama officials interpreted a "precipitous" drop in application volume after instituting its cap as families believing that the program was "over." Florida officials said that parents were "frustrated and angry" when national Back to School campaigns advertised SCHIP at a time when the program was closed. Still, the rapid enrollment recovery in most states after caps were lifted (as well as the strong spikes in enrollment during "open" periods in Florida and Utah) suggest that SCHIP still represents a needed and desirable product to parents.

Retention. There was consensus among key informants that rates of retention among SCHIP enrollees improved during and after caps. Few data were shared, but Montana estimated that its retention rate rose from 70 percent before the cap to 90 percent while the cap was in place. "People really pay attention to renewal when the threat of a waiting list is there," said the SCHIP director in North Carolina.

Conclusions And Policy Implications

SCHIP faced its greatest challenges during 2001–2003. Most states experienced three straight years of budget deficits, and a combined deficit topping $78 billion existed for FY 2004.[15] To balance their ledgers, states cut deeply into health programs, including SCHIP. Seven of the thirty-nine states with separate SCHIP programs took the most dramatic step available by capping program enrollment. Our interviews with officials in these states revealed that although it was painful, the decision to cap enrollment was consistent with policymakers' decisions in 1997 to adopt separate program models under SCHIP, which provide greater flexibility to control program growth and costs. Indeed, enrollment caps resulted in quick cost

"Policymakers reportedly paid a high political price as media and advocacy attention focused on children's growing unmet needs."

savings and, largely because of this, were lifted by the states relatively quickly.

Unfortunately, these savings came as a result of steep declines in enrollment, when thousands of children did not renew in time to retain coverage and untold uninsured-but-eligible children were not permitted to enroll. Undoubtedly, this loss of access to coverage caused hardships for children and their families. Caps were also painful for policymakers, who reportedly paid a high political price as media and advocacy attention focused on children's growing unmet needs. Invariably, this pressure, too, contributed to the quick reversal of caps.

Our interviews with SCHIP and CKF officials also shed light on a number of other lessons, many of which hold implications for policymakers in other states. First, caps were seen as the lesser of two evils. Most SCHIP and CKF officials we interviewed believed that enrollment caps, while painful, were preferable to cuts in other program areas. As controversial as this sounds, these respondents reasoned that it was more important to maintain the features that made SCHIP successful—including simplified enrollment, rich benefits, low cost sharing, and adequate provider reimbursement—even if it meant having to adopt temporary enrollment caps. They also pointed out that in contrast to caps, policy cuts in benefits, cost sharing, and reimbursement would have been more difficult to reverse in state legislatures once adopted. Unfortunately, testing this hypothesis by studying the relative impacts of alternative cost containment policies on enrollment was beyond the scope of this study.

Second, it was necessary to mitigate the negative effects of enrollment caps on families. State and CKF officials believed that a range of policy strategies helped accomplish this. These included (1) maintaining a waiting list (an important and useful tool for gauging the demand for coverage, serving families on a first-come, first-served basis as slots in the programs opened up, helping the programs rebound quickly once caps were lifted, and endorsing ongoing outreach); (2) simplifying renewal procedures (by preprinting forms, reducing verification, and adopting passive approaches that require families to respond only if their circumstances have changed so that eligible children do not unnecessarily lose coverage); and (3) modifying cost-sharing policies (such as extending grace periods for families that fall behind in their payments and eliminating lockout periods for families who are disenrolled because of premium nonpayment). Our analysis, however, found that only simplified renewal seemed to reduce rates of attrition; the other two practices could not be observed as having an effect on either enrollment attrition or recovery.

CAPPING ENROLLMENT UNDER SCHIP is a drastic step that can lead to large drops in children's coverage. SCHIP and CKF officials expressed the hope that budget circumstances would never require them to take such a drastic step again. But with health care costs rising, state economies in flux, and the federal reauthorization of SCHIP pending for 2007, states may indeed be confronted by the need to consider enrollment caps again. Perhaps the lessons learned by the states studied here can help others design policies that minimize the negative impacts on vulnerable children.

The authors acknowledge the Robert Wood Johnson Foundation, which funded the study, as well as the state and Covering Kids and Families officials who so generously shared their time and data with us.

NOTES

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8. C. Pernice and D. Bergman, "State Experience with Enrollment Caps in Separate SCHIP Programs," February 2004, http://www.nashp.org/Files/Enrollment_Cap_policy_brief_final.pdf (accessed 6 December 2005); and P. Silberman et al., *The North Carolina Health Choice Enrollment Freeze of 2001* (Washington: Kaiser Commission on Medicaid and the Uninsured, 2003).
9. An additional 25,000 undocumented children were also on a separate waiting list for the state-only funded portion of Healthy Kids.
10. Under Florida's system, children's enrollment was automatically renewed if premium payments were up to date and no changes to family circumstances were reported on preprinted renewal forms.
11. To offset potential negative effects of renewal policy changes, Florida increased children's continuous coverage period from six to twelve months and launched a renewal assistance program, Pathfinder.
12. The state exempted children in families whose income increased above Medicaid and M-SCHIP levels, thus making them eligible for SCHIP.
13. Maryland officials believe that up to one-third of these children might have left the program as a result of other policy changes that occurred at the same time as the cap, including the state's discontinuance of its subsidized employer-based coverage program that served approximately 200 children.
14. Utah also adopted passive renewal after it adopted time-limited enrollment periods.
15. National Conference of State Legislatures, *State Budget Update: February 2004* (Denver: NCSL, 2004).

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HEADLINES:

Healthy families program is no place to cut
November 16, 2008 *San Jose Mercury News* Article **Web Link**

Small firms shiver as health premiums rise
November 17, 2008 *Wall Street Journal* Article **Web Link**

Facing deficits, states get out sharper knives
November 16, 2008 *New York Times* Article **Web Link**

ARTICLES:

Healthy families program is no place to cut

November 16, 2008 – San Jose Mercury News
By: Editorial

So it's come to this: The governor who promised to provide health insurance for all of California's children now will add to the ranks of the uninsured.

Lesley Cummings, the director of California's Healthy Families program, said last week that Gov. Schwarzenegger's proposed budget cuts mean for the first time in the program's history, it will close its enrollment for children. This will make it impossible for tens of thousands of eligible children to obtain insurance in the months to come.

Alternatives exist. The governor could justify more money for Healthy Families because for every $1 the state invests, it gets $2 in federal funds. An increase in the tobacco tax, which he's supported in the past, could support the program.

Schwarzenegger thinks comprehensive health care reform will solve this problem,

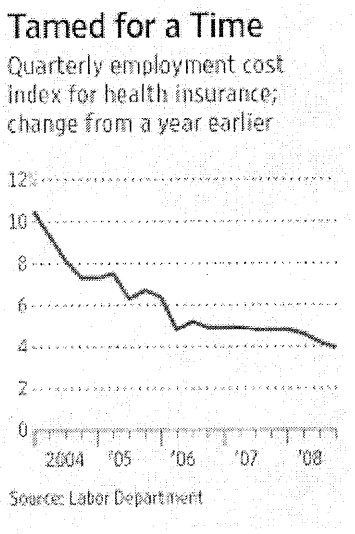
but getting this done anytime soon is a delusion. It's a cop-out, just as thousands of more families are losing employer-based insurance.

So while the governor is enjoying his next cigar, kids across the state will be heading for emergency rooms with problems that could have been addressed at far less public expense — not to mention less painfully — by a family doctor.

Small firms shiver as health premiums rise

November 17, 2008 – Wall Street Journal
By: Vanessa Fuhrmans

Already struggling in a tough economy, many small employers are about to face another big hit: markedly higher increases in health-insurance premiums as they head into 2009.



For many of these companies, the steeper increases couldn't come at a worse time, when the economy is weakening and credit is harder to come by.

"We can't pass these costs on to our customers; the market just won't bear it," said Daniel Lance, who owns E.CAB, a St. Petersburg, Fla., firm that produces finishes and fixtures for elevator-cab interiors.

After no increase last year, E.CAB's premiums jumped 75% to about $6,800 a month when its annual Blue Cross Blue Shield of Florida policy came up for renewal this month. Much of the jump was triggered by the hiring of a few older workers by the 25-employee firm, pushing it into a higher-cost actuarial bracket. E.CAB couldn't get a better price from rival insurers.

Rather than pass the cost on to his employees, who aren't required to contribute premiums for themselves though they do for family members, Mr. Lance said he's forgoing new wood-cutting equipment he had planned to purchase. "I just felt it was a bad time [to pass on costs]," he said. "The employees are having a tough enough time, too."

As hard as it has been for businesses to absorb ever-higher health-care costs each

year, the collective premiums they paid had actually climbed at a slower rate in recent years. But as small businesses begin to receive their annual renewal notices, employers and health-insurance brokers in the South, Midwest and California report noticeably steeper rises. Some premium increases being quoted to employers are double those quoted just a few months ago.

In a nationwide survey of 30 insurance brokers released by Citigroup last week, more said insurers were raising premiums at a faster rate than those who reported slowing increases.

The clearest evidence of acceleration comes directly from insurers themselves. As they released third-quarter earnings in recent weeks, WellPoint Inc., UnitedHealth Inc. and Humana Inc. all reported less aggressive pricing by competitors in a number of markets, making it easier to charge premiums that would assure a solid profit.

"Generally speaking, we've been increasing our pricing over the last several months and last several quarters with the thought in mind that it's going to be a lot more conservative in terms of the pricing environment and we're beginning to see that," said James Murray, Humana's chief operating officer, in its earnings conference call with analysts late last month.

For-profit health insurers have seen profit margins shrink this year in the face of higher-than-expected medical costs and pricing missteps, not to mention membership declines as more businesses drop or cut back coverage. While companies with 500 or more employees might have leverage to negotiate, health insurers are "being much more rigid" with smaller firms, said Edward Kaplan, national practice leader at Segal Co., an employee benefits consultancy.

Adding to upward pressure on prices could be dozens of not-for-profit Blue Cross and Blue Shield plans, whose investment portfolios have taken a beating in the recent market turmoil. In recent years, the not-for-profits have been under political pressure in their states to reduce their big surpluses from flush years by providing price breaks to customers. Analysts say they now may have more cause not to.

"Now that investment income is significantly less, we could see less concern about an embarrassment of riches and more about battening down the hatches," said Matthew Borsch, a Goldman Sachs analyst.

C. Steven Tucker, a health insurance broker for small businesses in Illinois, said his clients have been getting increases ranging between 28% and 31% this month, compared to typical increases of 18% to 20%. In Florida, brokers say many plans hit with high increases are high-deductible plans eligible to be used with a health savings account.

A few years ago, health insurers tried to win business with the new health savings accounts by charging low premiums, but since the most popular ones pay 100% of costs after a $1,500 to $3,000 deductible, their costs have been higher than anticipated. "Now the insurers are catching up," said John Sinibaldi, an employee-benefits consultant in Seminole, Fla.

Dottie Jessup, who owns bicycle shops in Clearwater and Palm Harbor, Fla., with her husband, Tom, said they and their 25 employees, who share premium costs 50-50, couldn't handle a 12.5% increase set to go into effect next month. "We don't know what kind of year we're going into," she said.

Instead, they went with their only other option: to raise one plan's deductible to $2,500 from $2,000 and the other to $3,500 from $2,850, in exchange for just a slight premium increase.

"Our concern is that we're getting to the point where we're wondering where this is all heading, because you can only reduce benefits and contain costs so much," she said. "What's our ability to provide benefits to our staff going to look like in the future?"

G. Leo DuMouchel, an Atlanta-area employee-benefits consultant, said that after years of negotiating smaller increases by raising deductibles and paring benefits, many of his small-business customers have run out of that option.

"They've pushed [cost-sharing] to the limit," said Mr. DuMouchel, who added he hasn't seen a premium increase for his clients below 17% since October, compared to 6% to 8% increases last summer. "They know employees can't handle any more."

Facing deficits, states get out sharper knives

November 16, 2008 – New York Times
By: Jennifer Steinhauer

Two short months ago lawmakers in California struggled to close a $15 billion hole in the state budget. It was among the biggest deficits in state history. Now the state faces an additional $11 billion shortfall and may be unable to pay its bills this spring.

The astonishing decline in revenues is without modern precedent here, but California is hardly alone. A majority of states — many with budgets already full of deep cuts and dependent on raiding rainy-day funds or tax increases — are scrambling to find ways to get through the rest of the year without hacking apart vital services or raising taxes.

Some governors, including Arnold Schwarzenegger in California and David A. Paterson in New York, have called special legislative sessions to deal with the crisis.

Others are demanding hiring freezes and across-the-board cuts. A few states are finding their unemployment insurance funds running dry, just as the ranks of out-of-work residents spike.

The plunging revenues — the result of an unusual assemblage of personal, sales, capital gains and corporate taxes falling significantly — have poked holes in budgets that are just weeks and months old and that came about only after difficult legislative sessions.

"The fiscal landscape," said H. D. Palmer, a spokesman for the California Department of Finance, "is fundamentally altered from where it was six weeks ago."

In Michigan, to reduce overtime costs, fewer streets will be salted this winter. In Ohio, where the unemployment rate is above 7 percent, the state may need a federal loan for the first time in 26 years to cover unemployment costs. In Nevada, which is almost totally dependent on sales taxes and gambling revenues, a health administrator said the state may be unable to pay claims in a few months.

In California, Mr. Schwarzenegger, a Republican, and state legislators are preparing to do battle over a proposed 1.5-cent sales tax increase, while in New York, Mr. Paterson, a Democrat, has proposed $5.2 billion worth of savings, principally cuts to Medicaid and education.

Even states where until recent months natural resource production has provided a

buffer — and fat surpluses — are experiencing a sudden reversal of fortunes as oil prices have declined.

"Frankly, I thought 2001 was really awful," said Scott D. Pattison, the executive director of the National Association of State Budget Officers, referring to the last big economic downturn. "It is even worse now."

He added, "This fiscal year will be really bad, and what is unfortunate is that I can't see how 2010 won't be bad too."

In keeping with recent economic trends, the states with the worst problems are those where housing booms morphed into a large-scale mortgage crisis over the last two years.

The current-year budget gap in Rhode Island represents over 11 percent of the state's entire general fund, in large part because of the high number of subprime loans. The story is similar in Arizona, California, Florida and Nevada.

In addition, the crisis in the financial markets had immediate and widespread impact on state budgets. States have lost revenues from capital gains taxes and bonuses that have evaporated, and growing job losses have reduced state income taxes while draining unemployment funds.

"What we are seeing is when fewer people are working there is less income tax and less spending," said Keith Dailey, a spokesman for Gov. Ted Strickland of Ohio, a Democrat.

Americans have also stopped shopping, which has hurt states that are heavily reliant on sales taxes, like Florida and Arizona. States that rely on tourism, like Nevada and Hawaii, have also been hurt by less consumer spending.

Further, the national credit crunch makes it harder for businesses to get loans, which trickles back into losses to states. When California was temporarily unable to gain access to the credit markets in the days leading up to the federal bailout package, state budget directors across the country noted the moment with horror.

The state's brief inability to pay bills because it could not get credit — California, like many states, regularly borrows money when it is short of cash in anticipation of revenue flowing in later — has since been largely interpreted as an outgrowth of the much larger national and international credit crisis. Still, some budget experts said the problem could be a harbinger: cities and counties with poor credit ratings could be cut off in the coming year, and there could be higher costs for issuing bonds.

"Just the fact that this was an issue at all is a big concern for every state," Mr. Pattison said. "Long-term bonds may be at risk. And I think states are going to have to accept that cost of debt is going to be higher."

In most states, budget directors and legislators have said that tax increases are not likely. A notable exception is California, where Mr. Schwarzenegger is seeking a 1.5-point increase to the state's 6.25-percent sales tax, although he is unlikely to get the necessary approval of Republican legislators.

In Oregon, moreover, Gov. Ted Kulongoski, a Democrat, has proposed a $1 billion economic stimulus plan centered on infrastructure improvements, which he envisions would be paid for by raising the state's gas tax by 2 cents per gallon and increasing a host of vehicle fees.

When regular legislative sessions resume in many states in January, other states will be more likely to look to rainy-day funds, when they are available, and deeper cuts to

services, most notably to K-12 education, which is generally a last-resort option among lawmakers.

"Most states have tried to protect K-12 and even higher ed," said Raymond Scheppach, the executive director of the National Governors Association, "but I think they are both going to be on the block."

Many states are expected to go to a second round of earlier cuts.

"We've cut universities, we've cut our infrastructure spending, we've prorated schools and asked employees for concessions twice," said Leslee Fritz, the spokeswoman for the Michigan State Budget Office. "All the different options out there we have already done more than once."

States are also looking to create large-scale infrastructure projects and other construction works as a means of stimulating the local economy.

The Washington governor, Christine Gregoire, a Democrat, is asking the federal government for hundreds of millions of dollars more for state and federal construction projects.

Ohio officials have already passed a stimulus package of $1.5 billion in bonds, to be used largely for public works, advanced and renewable energy projects, and the biomedical industry.

"States don't have a lot of economic stimulus tools," said Mr. Pattison of the budget officers' association, "but they have infrastructure."

Fewer than a dozen states have remained in the black this fiscal year, according to the Center on Budget and Policy Priorities, a liberal-leaning economic research group in Washington that tracks state budgets, and they are largely those in the West with oil and mineral resources at the ready.

"The oil-producing states were doing very well with oil at $120 a barrel," said Iris Lav, the deputy director of the center. "They may not do as well now."

More generally, Ms. Lav said, state budgets are "moving from the damaged to the devastated."

Agenda Item 4.a
11/19/08 Meeting

THE SACRAMENTO BEE sacbee.com

This story is taken from Sacbee / Capitol and California

Health plan for California kids may end new enrollment

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As California sheds jobs at an alarming rate, increasing the ranks of the uninsured, the state-run Healthy Families program for children is preparing to close enrollment for the first time in its 10-year history.

New enrollment in the program, which provides medical, dental and vision care to more than 900,000 children whose families earn too much to qualify for Medi-Cal but not enough to buy insurance, has averaged more than 27,000 a month during the past year.

That is an all-time high, and has already created a $17.2 million deficit in the program.

Lesley Cummings, executive director of the state's Managed Risk Medical Insurance Board, which administers Healthy Families, has told the board the only way to manage costs is to limit enrollment.

Failure to do, she said, could ultimately force the state to stop coverage for children who are already in the program.

Cummings' recommendation is expected to be discussed at a board meeting Wednesday. Without an infusion of new money – unlikely as California grapples with an $11.2-billion deficit – the board is expected to vote Dec. 17 on freezing enrollment the next day and establishing a waiting list.

Advocates for children say that with unemployment in California at 7.7 percent, the highest in a dozen years, 162,000 eligible children would be denied coverage between December and June.

They said families without coverage will have to seek care at free county health clinics, where available, and that many will turn to hospital emergency rooms as a last resort.

"More than ever, California families are relying on these essential services that provide affordable, comprehensive health coverage for their children," Wilma Chan, a vice president for Children Now, said in a statement.

Chan, a former member of the Assembly, called on the Legislature and Gov. Arnold Schwarzenegger to fully fund Healthy Families during the current special legislative session on the state budget and economy.

Even before the recent acceleration of job losses, health care advocates predicted that the budget the governor signed in September would make it impossible for more than 250,000 children to obtain health coverage during the next four years – adding to the ranks of 6.5 million Californians who are already uninsured.

While it was not widely publicized, Cummings said the budget also called for closing enrollment in Healthy Families after Dec. 18.

"The budget discussions were so protracted and complex that I don't think it was the first thought in most minds at the time," Cummings said.

The only development that could head off freezing enrollment, she said, is "more dollars to make up the shortfall."

"That has happened a few times in the past," she said. "But this is just such a mind-boggling, horrendous budget year, and there's lots of people needing lots of money in lots of programs," Cummings said.

Sen. Darrell Steinberg, who takes over as Senate president pro tem on Dec. 1, said that despite the state budget crisis, children's health care should be a top priority.

"I would urge (the Managed Risk Medical Insurance Board) to hold up on such a vote," said Steinberg, D-Sacramento. "There are a lot of moving parts, including a new administration in Washington and a Congress committed to putting children's health at or near the top of the agenda."

Steinberg said he has been in discussions with officials who administer the cash-flush First 5 programs in the state and with foundations "about stepping up."

He noted that President-elect Barack Obama has also signaled he wants to increase spending for the State Children's Health Insurance Program (SCHIP), the federal program that provides $2 for every $1 that California spends on Healthy Families.

But the federal government is also strapped for cash. Previous SCHIP expansions were vetoed by President Bush, who argued the program should stick to the working poor.

With the Republican president and Democratic-controlled Congress at an impasse, the funding allocated this year for the program is scheduled to run out in March.

Cummings said she has been heartened by news of the incoming administration's support for SCHIP. But she cautioned the state would still have to come up with the matching funds.

California has the largest SCHIP enrollment of any state in the nation, with more children in the program than the next two states combined.

Healthy Families has been credited with dramatically reducing the number of uninsured children in California. But as the program has grown, so have the state's costs.

In a memo, Cummings told her board members that "in the context of the state's fiscal emergency" they "cannot presume" there will be sufficient funding to offset the deficit.

"What is clear is that the board is required by law to manage the program within the funds provided," she said.

Call Aurelio Rojas, Bee Capitol Bureau, (916) 326-5545.

Children's Defense Fund

CHILDREN NOW

The Children's Partnership

PICO California

For Immediate Release
November 13, 2008

Contact:
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State Freezes Healthy Families Program

More than 162,000 eligible children at risk of falling through safety net and losing hope of needed health coverage

During this moment of severe economic hardship for California's working families, a program that has served as the health care life-line for more than 900,000 California children risks seeing its doors close to eligible children – for the first time in its more than 10-year history. Truly, this could not come at a worse time. Never before has the Healthy Families Program been more needed; enrollment into the low-cost Program is at an all-time high of an average 27,125 children per month.

Last week, the Managed Risk Medical Insurance Board (MRMIB), the agency that administers the Healthy Families Program, announced that they had been under-funded by $17.2 million.

Required to operate within financial means, MRMIB staff recommend wait-listing all children who apply for Healthy Families coverage beginning December 18, 2008. This will lead to more than 162,000 eligible children being denied needed health coverage by June 30, 2009. MRMIB will discuss the proposed waitlist and hear comments from the public on Wednesday, November 19, 2008, and will vote on the proposal in December. Unless a solution is found, doors would close on December 18, 2008.

Regrettably, in Governor Schwarzenegger's special session proposals, he chose to ignore the $17.2 million gap in funding.

"We understand the magnitude of the economic crisis. Yet, closing the door on the Healthy Families Program for the first time in its history is simply unconscionable. More than ever, California families are relying on these essential services that provide affordable, comprehensive health coverage for their children," stated Wilma Chan, Vice President of Children's Health and Education Policy at Children Now. "We call on the Legislature and the Governor to place a high priority on children's health and continue to fully fund Healthy Families in the special session."

This is just one of a number of budget cuts to Medi-Cal and Healthy Families that will lead to nearly 500,000 children losing their health coverage. This is occurring at a time when families are struggling to keep their heads above water during this economic downturn—when families need the support of programs, such as Medi-Cal and Healthy Families.

"When the Assembly Budget Committee meets this Friday, legislators have an opportunity to address this and other cuts to children's health coverage. They should work to ensure that all children who are eligible for Healthy Families and Medi-Cal get the care and services they need to remain in school, and out of California's emergency rooms. Any short-term savings from keeping children uninsured will be outweighed by the long-term costs of children not obtaining the preventative and ongoing health care that they need," concluded Ms. Chan.

The 100% Campaign, a collaborative effort of The Children's Partnership, Children Now and Children's Defense Fund, was created to ensure that all of California's children obtain the health insurance they need to grow up strong and healthy. http://www.100percentcampaign.org/

The PICO California Project is the united effort of 20 California congregation-community organizations affiliated with the PICO National Network. Collectively, we represent 350 congregations and 400,000 families statewide and are actively organizing in over 70 cities in Northern and Southern California.http://www.picocalifornia.org/

The Children's Partnership
Wendy Lazarus, Founder and Co-President – Contact Carrie Spencer at 310-260-1220 x12 to speak to Wendy, or contact Wendy directly at 310-710-9830
Kristen Golden Testa, California Health Program Director – 415-505-1332

Children Now
Wilma Chan, Vice President, Children's Health & Education Policy – Contact Ronald Pineda at 510-763-2444 x119 to speak to Wilma, or contact Wilma directly at 510-763-2444 x105

PICO California Project
Jim Keddy, Director – 916-402-5802
Rebecca Stark, Associate Director – 916-402-5804

Children's Defense Fund California
Deena Lahn, Policy Director – 510-663-2984
Cliff Sarkin, Senior Policy Associate – 510-663-1294

LOCAL HEALTH PLANS of California
Promoting Health Care For All

November 14, 2008

Kim Belshé
Secretary
California Health and Human Services Agency
1600 Ninth Street
Sacramento, CA 95814

RE: ENROLLMENT CAP FOR HEALTHY FAMILIES

Dear Secretary ~~Belshé~~: Kim

On behalf of the Local Health Plans of California, I am writing to offer our support and assistance for a solution to the prospect that the Healthy Families Program enrollment will be capped and the development of a waiting list that is estimated to reach as high as 162,000 children.

We are aware of the unparalleled fiscal challenge facing state government, and we are confident that you and your staff are working very hard to protect the populations served by the programs of the Health and Human Services Agency and to be part of the solution to state's fiscal challenges. We know how incredibly difficult these challenges are from our own experience from the front lines of delivering services.

In a time of a severe shortage of resources, we need to use all the leverage that we have to sustain critical programs. Healthy Families with the SCHIP two-thirds match by the federal government is a very highly leveraged program, and Medi-Cal with its 50% match is leveraged in terms of a cutback benefiting the General Fund having a 2 to 1 or 1 to 1 loss in funds for these programs.

Therefore, we can least afford to reduce these programs and may need to be considering funds from other programs that can be required to sustain Healthy Families in a way that will allow the state to accomplish the leveraged match. We are aware that these solutions might require legislative action in a short time frame, but are hopeful that the legislature could be persuaded to act to protect coverage of children in the Healthy Families program.

Sincerely,

Leona Butler

Leona Butler
Chief Executive Officer
Santa Clara Family Health Plan

Cc: Managed Risk Medical Insurance Board

1225 Eighth Street, Suite 440 ★ Sacramento, CA 95814
Phone: (916) 448-8292 ★Fax: (916) 448-8293 ★ Email: lhpc.org

CHILDREN'S HEALTH INITIATIVE OF GREATER LOS ANGELES

Agenda Item 4.a
11/19/08 Meeting

November 17, 2008

California Managed Risk Medical Insurance Board
P.O. Box 2769
Sacramento, CA 95812-2769
FAX (916) 324-4878

RE: Healthy Families Program

Dear Managed Risk Medical Insurance Board:

On behalf of the Children's Health Initiative (CHI) of Greater Los Angeles, we ask that the Board refrain from taking any immediate action that would result in either disenrolling enrollees from the Healthy Families Program or establishing a wait list, especially in light of the state's current budget negotiations in the special session and federal efforts to provide/increase state support through an economic stimulus package.

We recognize the dire economic situation that the Managed Risk Medical Insurance Board (MRMIB) and the state face and understand the importance of making fiscally sound decisions; nonetheless, we believe that it is premature to begin to take adverse action for the Healthy Families Program. As your estimates indicate, this would result in over 160,000 children who would be wait listed. Delaying such action will allot more time for the state's budget deficit to be addressed during the special session. It will also allow more time for federal efforts that would provide fiscal relief to states through an economic stimulus package. This could result in additional funding for California estimated at $2 billion. As you know, the Healthy Families Program needs $17 million in General Funds to receive $34 million in federal matching funds to cover these children.

The CHI is a broad coalition of business, labor, providers, advocates, county agencies, private foundations and other organizations that has come together to secure health coverage for all uninsured children in Los Angeles County. In the past four years, we have enrolled over 100,000 children in Medi-Cal and Healthy Families and over 40,000 children in our local Healthy Kids program. Moreover, we have experienced the negative impact of imposing a wait list and enrollment hold on our local Healthy Kids 6-18 program. Taking such measures resulted in confusion for members, preventing some families from enrolling their children in the Healthy Kids 0-5 program that remained open to enrollment. Given our experience, we recommend avoiding such disruption on a statewide basis.

We are hopeful that by delaying this action, MRMIB will have more options to address its budget shortfall given potential federal relief and pending state budget actions. This, in turn, would ensure that thousands of children will be able to maintain the comprehensive coverage that they deserve. We look to your leadership to ensure that no premature action is taken to freeze enrollment into the Healthy Families Program and disenroll children while these state and federal efforts are underway.

Thank you for your consideration and commitment to providing health care coverage to California's children and their families.

Sincerely,

Lucien Wulsin Jr.
Director, Insure The Uninsured Project
Chair, Policy Change Workgroup, Children's Health Initiative
of Greater Los Angeles

Encl.

c: Lesley Cummings, MRMIB
L.A. County Delegation

CHILDREN'S HEALTH INITIATIVE OF GREATER LOS ANGELES

November 17, 2008

The Honorable Karen Bass
Speaker of the Assembly
State Capitol
P.O. Box 942849
Sacramento, CA 94249-0047
FAX (916) 319-2147

RE: Healthy Families Program

Dear Speaker Bass:

On behalf of the Children's Health Initiative (CHI) of Greater Los Angeles, we look to your leadership to urge the Managed Risk Medical Insurance Board (MRMIB) to refrain from taking any immediate action that would result in either disenrolling enrollees from the Healthy Families Program or establishing a wait list, especially in light of the state's current budget negotiations in the special session and federal efforts to provide/increase state support through an economic stimulus package.

We recognize the dire economic situation that MRMIB and the state face and understand the importance of making fiscally sound decisions; nonetheless, we believe that it is premature to begin to take adverse action for the Healthy Families Program. As MRMIB estimates indicate, this would result in over 160,000 children who would be wait listed. Delaying such action will allot more time for the state's budget deficit to be addressed during the special session. It will also allow more time for federal efforts that would provide fiscal relief to states through an economic stimulus package. This could result in additional funding for California estimated at $2 billion. As you know, the Healthy Families Program needs $17 million in General Funds to receive $34 million in federal matching funds to cover these children.

The CHI is a broad coalition of business, labor, providers, advocates, county agencies, private foundations and other organizations that has come together to secure health coverage for all uninsured children in Los Angeles County. In the past four years, we have enrolled over 100,000 children in Medi-Cal and Healthy Families and over 40,000 children in our local Healthy Kids program. Moreover, we have experienced the negative impact of imposing a wait list and enrollment hold on our local Healthy Kids 6-18 program. Taking such measures resulted in confusion for members, preventing some families from enrolling their children in the Healthy Kids 0-5 program that remained open to enrollment. Given our experience, we recommend avoiding such disruption on a statewide basis.

We are hopeful that by delaying this action, MRMIB will have more options to address its budget shortfall given potential federal relief and pending state budget actions. This, in turn, would ensure that thousands of children will be able to maintain the comprehensive coverage that they deserve. We look to you to ensure that MRMIB does not take any premature action to freeze enrollment into the Healthy Families Program and disenroll children while these state and federal efforts are underway.

Thank you for your leadership and commitment to providing health care coverage to California's children and their families.

Sincerely,

Lucien Wulsin Jr.

Lucien Wulsin Jr.
Director, Insure The Uninsured Project
Chair, Policy Change Workgroup, Children's Health Initiative
of Greater Los Angeles

Encl.

c: Lesley Cummings, MRMIB
L.A. County Delegation

HEALTH INITIATIVE OF GREATER LOS ANGELES

COALITION PARTICIPATING ORGANIZATIONS*

Alta Med Health Services Foundation
American Apparel
Asian Pacific American Legal Center
Asian Pacific Healthcare Venture
Blue Shield of California Foundation
California Small Business Association
California Community Foundation
California Medical Association
California Teachers' Association
CaliforniaKids HealthCare Foundation
Cedars-Sinai Medical Center
Children's Health Council
Children's Hospital Los Angeles
Children's Planning Council
City of Los Angeles Commission on Children, Youth and their Families
Coalition for Community Health
Community Clinic Association of Los Angeles County
Community Health Councils, Inc.
Community Health Plan
Eisner Pediatric and Family Medical Center
First 5 LA
Hospital Association of Southern California
Insure the Uninsured Project
Kaiser Permanente
Korean Resource Center
L.A. Care Health Plan
LA Health Action
LA Regional Food Bank
Latino Coalition for a Healthy California
LA Voice PICO
Los Angeles Area Chamber of Commerce
Los Angeles County Department of Health Services
Los Angeles County Department of Public and Social Services
Los Angeles County Medical Association
Los Angeles County Office of Education
Los Angeles Unified School District
Maternal and Child Health Access
National Health Foundation
National Immigration Law Center
Northeast Valley Health Corporation
Service Employees International Union 99
Shriners Hospital for Children – Los Angeles
The California Endowment
UCLA Center for Health Policy Research
UniHealth Foundation
United Teachers of Los Angeles
100% Campaign (*a collaborative of Children Now, Children's Defense Fund and the Children's Partnership*)

Media Contact:
Andrea Van Hook
Director, Marketing & Communications
L.A. Care Health Plan
Tel: (213) 694-1250 x4142
Cell: (818) 606-0962
AVanHook@LACare.org

* This is a partial list of Coalition participants as of November 2008

ITUP
INSURE THE UNINSURED PROJECT

November 17, 2008

Managed Risk Medical Insurance Board
P.O. Box 2769
Sacramento, CA 95812-2769

RE: Healthy Families Program Wait List

Dear Managed Risk Medical Insurance Board Members:

Insure the Uninsured Project (ITUP) urges the Board not to establish a wait list for the Healthy Families Program. The federal economic stimulus package under consideration in Congress will provide some relief from the state's financial situation, making a Board action premature given the Legislature and Governor's strong support for Healthy Families.

The proposed waitlist would result in over 160,000 children who could be waitlisted over the next 6 months. Enacting a wait list would be devastating to these hard working families in a time of economic crisis.

Thank you for your consideration and commitment to providing health care coverage to California's uninsured children and their families.

Sincerely,

Lucien Wulsin

2444 Wilshire Blvd. Suite 415 • Santa Monica, CA 90403
Tel: (310) 828-0338 • Fax: (310) 828-0911
email: info@itup.org • www.itup.org

Funded by grants from
The California Endowment
The California Wellness Foundation
Blue Shield of California Foundation
L.A. Care Health Plan

-----Original Message-----
From: ITUP [mailto:info@itup.org]
Sent: Monday, November 17, 2008 12:32 PM
To: Cummings, Lesley
Subject: MRMIB Waitlist Proposed

MRMIB Waitlist Proposed **November 17, 2008**

Dear Lesley,

MRMIB is considering imposing a waiting list on the Healthy Families Program at its Wednesday, November 19, 2008 board meeting. Those of you who wish to comment on this proposal should do so as quickly as possible.

At a recent board meeting, MRMIB discussed the growth in enrollment for Healthy Families and suggested that a waiting list be considered to cap enrollment. Enrollment has been high with an average of 27,000 children joining each month due to the economic downturn. High enrollment has led to a $17.2 million deficit, with over 900,000 children currently enrolled. A waitlist for 6 months could cause backlog of 163,000 children.

A public hearing will be held Wednesday, November 19, 2008, where there will be an opportunity to comment. It would be important for the board to consider an alternative to the waitlist and to allow the legislature to consider whether it wishes to freeze enrollment in this wonderful program or fill the current shortfall.

There is plenty of opportunity, but a short time, to make your opinions heard.

Hope you had a wonderful weekend.

Sincerely,
Lucien and the ITUP team

Agenda Item 4.a
11/19/08 Meeting

Sean Miller
1250 Grove St. #7
San Francisco, CA 94117

November 17, 2008

Managed Risk Medical Insurance Board
P.O. Box 2769
Sacramento, CA 95812-2769

Dear Honorable Members of the Managed Risk Medical Insurance Board:

Re: *State Budget Update - Current Year Deficiency in HFP: Consideration of Findings Authorizing Implementation of Waiting List*

As a citizen and registered voter of California, I **oppose** any action that might refuse or delay access to healthcare to some of the state's most vulnerable citizens. As you convene your board meeting this Wednesday, November 19, 2008 I urge you to delay authorizing the implementation of a waitlist for California's Healthy Families Program. It is antithetical for the MRMIB to delay or refuse access to healthcare for the children of this state's working families. This action could put these children at significant risk of not receiving timely medical care. Without coverage they will not benefit from preventative care, get sicker and end up in emergency rooms more often.

Increasingly, families across the state are losing private health insurance plans due to increased costs suffered directly or by their employers forced to discontinue these benefits. As you know, the Healthy Families Program provides affordable comprehensive medical coverage to individuals whose employers do not provide coverage and whose income is too high to qualify for Medi-Cal. Enrollment is at an all-time high. Currently, 883,589 children (over 11,000 children in San Francisco alone) rely on this program, and about 27,125 new applicants enroll each month. A plan to waitlist enrollees for up to six months would leave approximately 160,000 children in "limbo".

This is a crucial matter not only for children but also for the state's healthcare professionals who rely on providing consistent, timely and uninterrupted medical care so that our patients have the best opportunity for a successful recovery. As a physical therapy student nearing the end of my education and who plans to work with children of working families, I understand their timely medical needs. Uninterrupted healthcare is crucial to quicker recovery from injury or disease and a return to daily activities like coloring or playing soccer on the weekend. Shutting the door or even delaying care could lead to irreversible long-term consequences for the pediatric patient.

Echoing the sentiment of incoming Senate Pro-Tempore, Darrell Steinberg, I urge you to delay action on the waitlist. Additionally, I encourage you to advise Governor Schwarzenegger and our current and newly elected Congress to enhance funding for the Healthy Families Program in California by demanding that a federal economic stimulus plan not exclude the healthcare needs of our children.

Sincerely,

SEAN MILLER,
Student Physical Therapist

cc: The Honorable Nancy Pelosi, Speaker of the U.S. House of Representatives
The Honorable Arnold Schwarzenneger, Governor of California

Agenda Item 4.a
11/19/08 Meeting

November 12, 2008

PICO California

PICO California
2510 J Street, Suite 200
Sacramento, CA 95816
(916) 447-7959
(916) 447-7955 fax
picocalifornia.org

100% Campaign Headquarters
1212 Broadway, 5th Floor
Oakland, CA 94612
(510) 763-2444
(510) 763-1974 fax
100percentcampaign.org

The Children's Partnership
1351 3rd St. Promenade
Suite 206
Santa Monica, CA 90401
(310) 260-1220
(310) 260-1921 fax

Children Now
1212 Broadway
Fifth Floor
Oakland, CA 94612
(510) 763-2444
(510) 763-1974 fax

1510 J Street, Suite 115
Sacramento, CA 95814
(916) 379-5256
(916) 443-1204 fax

Children's Defense Fund
2201 Broadway, Suite 705
Oakland, CA 94612
(510) 663-3224
(510) 663-1783 fax

3655 S. Grand Avenue
Suite 270
Los Angeles, CA 90007
(213) 749-8787
(213) 749-4119 fax

Governor Arnold Schwarzenegger
Office of the Governor
State Capitol
Sacramento, CA 95814
FAX (916) 558-3160

Re: Protecting Children's Health Insurance in this Year's Budget

Dear Governor Schwarzenegger:

As you convene the special session on the 2008-09 budget, the 100% Campaign – a collaborative effort of The Children's Partnership, Children Now, and the Children's Defense Fund California – and PICO California strongly urge you to protect children's health coverage. As you know, having health insurance is a key economic stabilizer for working families who are facing more significant financial hardships than ever. During this economic recession, it is California families, not just the state budget, who are hurting. They need to be able to count on a strong safety net. As you consider how to fill the current year's budget deficit, we urge you to protect children's health insurance so that the economic situation does not become even worse for our state's working families.

During this past year of economic downturn, 19 states have *expanded* or streamlined their children's health care programs. Our state – traditionally a leader in this area – has taken steps backward and now risks falling from 40th in the nation to dead last in terms of securing access to health care for its children. ***California should not roll back Medi-Cal and Healthy Families at precisely the time that working families rely most on these essential children's coverage programs.***

Over four million children count on California's health insurance programs for coverage. On their behalf, we urge you to prioritize children's health in the special session by preserving children's coverage. Specifically, we recommend that you:

- **Restore full funding for the Healthy Families Program.** As evidenced by the record high rate of new enrollments (27,125 per month), more parents are losing jobs or health benefits and are seeking low-cost Healthy Families coverage for their children. Healthy Families is currently facing a $17.2 million deficiency for the year. We were greatly disappointed that your special session budget did not fully fund this important program. We urge you to do so. Otherwise, more than 162,000 children who would have enrolled will be wait-listed and may never be allowed to enroll in this successful coverage program.
- **Do not implement new barriers to Medi-Cal.** Mid-Year Status Reports (MSRs) in Medi-Cal have been shown to serve as a major barrier to coverage, resulting in eligible children losing their coverage. If implemented, MSRs will cause 250,000 eligible, enrolled children to join the ranks of the uninsured by December 2011. Moreover, a university-based study noted that, when similar bureaucratic hurdles were removed for children in Medi-Cal, the state saved $17 million in reduced child hospitalizations.

- **Maintain health benefits for legal immigrants.** If children are required to wait until they have been in the United States for five years to be eligible for full-scope benefits, many thousands of California families will be forced to use the emergency room for primary care.
- **Preserve health coverage for poor parents.** Evidence shows that children are more likely to get health insurance and use needed services when their parents are covered as well. With this in mind, we must work to keep families covered, especially in economic downturns when families most need the health care safety net.
- **Target the impact of any assistance from Congress.** Maintaining health benefits for children and families is an economic issue. Most of the discussions regarding a pending federal economic stimulus package include relief to states to support their Medicaid and SCHIP programs. Should such federal relief become available, we strongly urge that California use these funds for their intended purpose: to keep children and families healthy. A portion of the estimated $2 billion total funds that would come to California would be enough to fully fund the Healthy Families deficiency, undo the short-sighted MSR policy in Medi-Cal, and otherwise continue to provide existing Medicaid and SCHIP coverage and benefits to children and their families.

Our state has taken commendable steps to cover more children in recent years. We truly applaud the role you have played in that progress and appreciate your commitment to children's health. However, your recent proposals to balance the budget include policies that run in direct opposition to your past actions and often-stated commitment to covering all children. Because being in good health is what's best for children, and healthy children are what's best for the future finances of the state, we call on you to step up once again and protect children during this special session.

Sincerely,

Wendy Lazarus
Founder and Co-President
The Children's Partnership

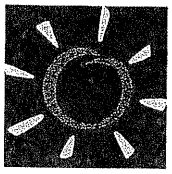
Jim Keddy
Director
PICO California

Ted Lempert
President
Children Now

Deena Lahn
Policy Director
Children's Defense Fund California

CC: Susan Kennedy, Chief of Staff, Office of the Governor
Daniel Zingale, Senior Advisor, Office of the Governor
Herb Schultz, Senior Health Policy Advisor, Office of the Governor
Richard Figueroa, Health Care Advisor, Office of the Governor
Jennifer Kent, Deputy Director of Legislation, Office of the Governor
Kim Belshé, Secretary, Health and Human Services Agency
Sandra Shewry, Director, Department of Health Care Services
Lesley Cummings, Executive Director, Managed Risk Medical Insurance Board
Toby Douglas, Deputy Director of Medical Services, Department of Health Care Services

Agenda Item 4.a
11/19/08 Meeting



November 18, 2008

The California Managed Risk Medical Insurance Board
1000 G Street, Suite 450
Sacramento, CA 95814

RE: Healthy Families Wait List

Dear Managed Risk Medical Insurance Board Members:

On behalf of L.A. Care, I am writing regarding the establishment of a Healthy Families Program wait list due to insufficient state funds in the current year to support projected program enrollment. Although I understand the Healthy Families Program has statutory requirements to operate with fiduciary oversight, I am asking your Board to not impose a wait list at this time as there are other feasible options to explore.

By establishing a wait list, California's children become the victims of California's delay in passing a budget. $14.1 million of the $17.2 million General Fund deficit is because the state budget assumption that MRMIB would implement budget saving reductions on November 1, 2008. However, due to the delay of passage of the budget, the budget reductions will not occur until February 1, 2009.

President-Elect Obama and key congressional leaders have strongly voiced their commitment to putting children's health care coverage at the top of their agenda. Congressional leaders have indicated they will consider an economic stimulus package that could result in increased federal matching rates for Medicaid, which could potentially provide $2 billion in assistance for California's health programs. In addition, Congress will shortly begin discussions on renewing the SCHIP program in response to its current authorization expiration in March 2009.

Instead of imposing a wait list for the Healthy Families Program, L.A. Care urges your Board to work with the Governor and Legislature to provide the $17 million in funding needed to continue the program. Incoming Senate Pro Tempore Darrell Steinberg has also urged your Board to not impose a wait list. Senator Steinberg has cited all the moving parts in Washington and Sacramento as reasons to delay implementing a wait list.

While I appreciate your Board's need to be fiscally responsible and adhere to statutory requirements, there are other options that can be taken to so that a wait list does not have to be implemented. I appeal to you to actively pursue the opportunities for additional program funding and to not impose a wait list and harm California's children.

Sincerely,

Howard A. Kahn
Chief Executive Officer

cc: Lesley Cummings, Executive Director, MRMIB
L.A. Care Board of Governors